GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2021

Michael Fields
Advanced Teaching Concepts Inc
P.O. Box 158
South Lyon, MI 48178

RE: License #: AS630087198
Investigation #: 2021A0988027
Novi Oaks

Dear Mr. Fields:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On September 13, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Kenyatta Lewis, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2078

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS630087198
Investigation #:	2021A0988027
Complaint Receipt Date:	07/16/2021
Investigation Initiation Date:	07/19/2021
Report Due Date:	09/14/2021
Licensee Name:	Advanced Teaching Concepts Inc
Licensee Address:	60674 Russell Lane South Lyon, MI 48178
Licensee Telephone #:	(248) 486-5368
Administrator:	Michael Fields
Licensee Designee:	Michael Fields
Name of Facility:	Novi Oaks
Facility Address:	24701 Dinser Novi, MI 48374
Facility Telephone #:	(248) 449-3119
Original Issuance Date:	03/20/2000
License **Status:**	REGULAR
Effective Date:	09/24/2020
Expiration Date:	09/23/2022
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
There is concern that staff would not be able to evacuate the residents in an emergency.	No
On 05/21/2021, Resident D fell out of bed at night and staff did not notice until the next morning. Resident D should be checked every two hours. On an unknown date Resident D was told he could not get out of bed until staff was available. Resident D stayed in bed until 12:30 PM.	No
Additional Findings	Yes

III. METHODOLOGY

07/16/2021	Special Investigation Intake 2021A0988027
07/19/2021	Special Investigation Initiated - Telephone I spoke to Dawn Krull, Office of Recipient Rights (ORR).
07/19/2021	APS Referral Adult Protective Services (APS) referral made by ORR.
07/19/2021	Contact - Document Received I received an email from Dawn Krull that contained an incident report (IR) dated 05/21/2021, resident record information for Resident D and Resident J.
07/27/2021	Inspection Completed On-site I conducted interviews with direct care worker (DCW) Billy Williams and LaToya Washington
09/13/2021	Contact - Telephone call made I spoke to Open Arms Support Coordinator, Jamie Sprung.
09/13/2021	Contact - Telephone call made I interviewed the complainant via telephone.
09/13/2021	Contact - Telephone call made I interviewed licensee designee, Mike Fields, and Program Manager Cody Sheldon separately, via telephone.

09/13/2021	Contact - Document Received I received May 2021 fire drills from Mr. Sheldon via email
09/13/2021	Contact - Telephone call made I interviewed home manager, Jennifer Gray via telephone.
09/13/2021	Contact - Telephone call made I conducted a 2nd interview with DCW, LaToya Williams via telephone
09/13/2021	Contact - Document Received I received staff schedules, Resident B's bed check logs, and Resident J's health care chronological (HCC) logs via email from Dawn Krull, ORR.
09/13/2021	Exit Conference I conducted the exit conference with Mr. Fields via telephone. I shared my findings and requested a corrective action plan (CAP)

ALLEGATION:

There is concern that staff would not be able to evacuate the residents in an emergency.

INVESTIGATION:

On 07/16/2021, I received a complaint from Oakland Community Health Network Office of Recipient Rights (ORR). The allegations were received from open arms supports coordinator, Jamie Springs, regarding concerns that some of the staff at Novi Oaks not being physically able to evacuate Resident D in an emergency. Resident D no longer resides at Novi Oaks.

On 07/19/2021, I initiated the special investigation by interviewing to Dawn Krull, (ORR) via telephone. Ms. Krull stated that APS would not investigate the allegations because Resident D no longer resides at Novi Oaks. Resident D moved out on 05/23/2021. Ms. Krull stated that she received the allegations on 05/27/2021, via an incident report (IR) dated 05/24/2021, authored by open arms supports coordinator, Jamie Springs. Ms. Krull reported the allegations to The Department when she realized that no referral was completed in May 2021.

On 07/27/2021, I conducted an unannounced onsite where I conducted brief interviews with direct care workers (DCW) Billy Williams and LaToya Washington. Mr. Williams and Ms. Washington denied the allegations and stated that all of the staff are physically capable of evacuating Resident D in case of an emergency. During the onsite, Resident J needed assistance, so I concluded my interview and left my business card for the home manager.

On 09/13/2021, I spoke to Open Arms Support Coordinator, Jamie Springs. Ms. Spring stated that she did not have any concerns regarding the staff at Novi Oaks not being able to physically capable of evacuating residents in case of an emergency.

On 09/13/2021, I interviewed the complainant via telephone. The complainant stated that some of the staff members are obese and have difficulty with mobility. The complainant did not provide the names of the staff members of concern.

On 09/13/2021, I interviewed licensee designee, Mike Fields, and Program Manager Cody Sheldon separately, via telephone. Mr. Fields stated that all of the DCW's are trained and capable of evacuating residents in case of an emergency. Fire drills and E-scores are completed per policy. Mr. Sheldon reiterated the information provided by Mr. Fields and stated that Resident D lived at Novi Oaks for a short period of time. Resident D was admitted on 05/10/2021 and moved out on 05/23/2021. Mr. Sheldon stated that he would forward the May 2021 fire drill log to me via email.

On 09/13/2021, I received May 2021 fire drills from Mr. Sheldon via email. I noted that a fire drill was completed on 05/11/2021 at 7:45 PM. I noted that five residents were evacuated in 1 minute, 17 seconds by DCW Rosalind Hogan and home manager, Jennifer Gray.

On 09/13/2021, I interviewed home manager, Jennifer Gray via telephone. Ms. Gray stated that she had no concerns regarding any of the staff being able to evacuate the residents during an emergency, in a timely manner. Ms. Gray stated that she provided the E- Scores to Ms. Krull, ORR and would make sure that I received a copy of the E-Scores as well.

On 09/13/2021, I received staff schedules, Resident B's bed check logs, fire drill E-scores, and Resident J's health care chronological (HCC) logs via email from Dawn Krull, ORR. I noted that there were two or three staff on schedule for each shift during the month of May 2021. I also noted that E-Scores were completed on 05/11/2021. The evacuation score was 1.52 which is rated as slow. A prompt evacuation score is 1.5 or less. The home was just shy of reaching a prompt evacuation score within one day of Resident D being admitted to Novi Oaks.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered from the complainant, supports coordinator Jamie. Springs, Dawn Krull, ORR and Novi Oaks staff, I did not conclude that the licensee failed to have sufficient staff on duty to ensure the protection of the residents. There is not sufficient information to establish that the staff at Novi Oaks are physically incapable of evacuating Resident D in case of an emergency.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 05/21/2021, Resident D fell out of bed at night and staff did not notice until the next morning. Resident D should be checked every two hours. On an unknown date Resident D was told he could not get out of bed until staff was available. Resident D stayed in bed until 12:30 PM.

INVESTIGATION:

On 07/16/2021, I received a complaint from Oakland Community Health Network Office of Recipient Rights (ORR). The allegations were received from open arms supports coordinator, Jamie Springs, regarding allegations that on 05/21/2021, Resident D fell out of bed in the middle of the night and staff did not find him until 6:30 AM. Resident D should be checked every two hours. Additionally, on an unknown date, Resident D stayed in bed until 12:30 PM after an unknown staff member told him he could not get up until another staff person was available to assist.

On 07/19/2021, I initiated the special investigation by interviewing to Dawn Krull, (ORR) via telephone. Ms. Krull stated that she received the allegations on 05/27/2021, via an incident report (IR) dated 05/24/2021, authored by open arms supports coordinator, Jamie Springs. Ms. Krull reported that on 05/21/2021Resident D fell out of bed and laid on floor for several hours. Direct care workers (DCW) are supposed to check on his roommate, Resident J every hour during sleeping hours, due to seizures. If DCW's checked on Resident J, they would have found Resident D lying on the floor.

On 07/19/2021, I received an email from Dawn Krull that contained resident record information for Resident D and Resident J and an incident report (IR) dated 05/21/2021 authored by DCW LaToya Williams. I reviewed Resident J's individual plan of service (IPOS) and noted that Resident J requires hourly visual bed checks during sleeping hours. I also noted that Resident J is non-verbal. I reviewed Resident D's IPOS and noted that Resident D requires hourly visual checks, and that Relative D would supply a full-length bed rail for Resident D's bed. I reviewed the IR and noted that Ms. Williams documented that on 05/21/2021 at 6:00 AM, Ms. Brown Epperson heard Resident D calling her name and found him on the floor. Ms. Brown-Epperson asked Ms. Williams to assist her in getting Resident D from the floor. Resident D was observed with a scratch on his head.

On 07/27/2021, I conducted an unannounced onsite where I conducted brief interviews with direct care workers (DCW) Billy Williams and LaToya Washington. Mr. Williams and Ms. Washington denied the allegations and stated that Resident moved out in May 2021. I stopped my interviews due to Resident J needing assistance from Mr. Williams and Ms. Washington.

On 09/13/2021, I spoke to Open Arms Support Coordinator, Jamie Springs. Ms. Spring stated that she did not have any concerns regarding the staff at Novi Oaks. Most of the staff are long term employees who take good care of the residents. Ms. Springs stated that Resident D had a google pod that he used to call family members, and listen to music, etc. Ms. Springs stated that Resident D contacted his relatives several times each day and it doesn't make sense that if he fell in the middle of the night, no staff would have heard him, or that he didn't call Relative D via his google pod.

On 09/13/2021, I interviewed the complainant via telephone. The complainant stated that Resident D was moved out of Novi Oaks within 11 days of being admitted because there were too many concerns regarding Resident D's safety. The complainant stated that staff used a blanket with handles to transfer Resident D from his bed to his wheelchair. The blanket is made of silky material that is slippery. The complainant stated that this type of blanket was not supposed to be used to transfer Resident D.

On 05/21/2021, the staff left the silky transfer blanket under Resident D after he was put in bed, which caused him to slip out of the bed. Resident D had a scratch and rug burns to his head. The complainant stated that Resident D reported that according to the google pod, he fell out of bed at 3:30 AM. The google pod is set to motion detection and there was no motion detection noted for three hours until 6:30 AM. On another date, Resident D told a DCW (name not provided) that was not able to get up for the day until 12:30 PM, because the staff were busy with another resident. The complainant stated that this only happened one time.

On 09/13/2021, I interviewed licensee designee, Mike Fields, and Program Manager Cody Sheldon separately, via telephone. Mr. Fields stated that all of the allegations are false. Mr. Fields stated that a bed was held for six months waiting for Resident D to be

admitted because his relatives were having a hard time accepting that he should move out of the family home. Mr. Fields stated that hourly bed checks were completed for both Resident D and Resident J and there is no way that Resident D was on the floor unattended for three hours. Mr. Fields also stated that Resident D liked to sleep in until around Noon every day. If Resident D had to wait for staff to be available to assist him, he didn't have to wait for a long time. Mr. Sheldon stated that ORR completed an investigation and did not substantiate any of the allegations.

On 09/13/2021, I interviewed home manager, Jennifer Gray via telephone. Ms. Gray stated that the allegations are totally false. Ms. Gray corroborated the information provided by Mr. Fields and stated that both Resident D and Resident J were checked on an hourly basis and that Resident D did not like to get out of bed before Noon.

On 09/13/2021, I conducted a second interview with DCW, LaToya Williams via telephone. Ms. Williams stated that she worked double shift, with DCW Taira Brown-Epperson, from 3:00 PM to 7:00 AM on 05/20/2021. Ms. Williams stated that she and Ms. Brown-Epperson completed hourly checks on Resident D and Resident J. Ms. Williams stated that Resident D did not fall before 6:00 AM because she or Ms. Brown-Epperson would have found him and assisted him. Ms. Williams corroborated the information provided by Ms. Gray and Mr. Fields regarding Resident D sleeping in until late morning, early afternoon. Ms. Williams stated that there was a day (date unknown) when Resident D did not want to get out of bed when staff asked him to. At approximately 12:30 PM, Resident D said he was ready to get up and Ms. Williams told him he had to wait a few minutes because she was helping another staff with Resident J, who requires two-person assist. Resident D may have waited about 10 minutes before he was assisted from his bed to his wheelchair.

On 09/13/2021, I received staff schedules, Resident B's bed check logs, fire drill E-scores, and Resident J's health care chronological (HCC) logs via email from Dawn Krull, ORR. I noted that there were two or three staff on schedule for each shift during the month of May 2021. I confirmed that Ms. Williams and Ms. Brown-Epperson worked a double shift on 05/21/2021. I reviewed Resident J's HCC notes and noted that the information documented corroborated the information provided by Ms. Williams, Ms. Gray and Mr. Fields. I also reviewed Resident J's bed check log and noted that he shares a bedroom with Resident D. Staff initials were recorded each hour on Resident J's bed check log.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on the information that I gathered during the investigation from interviews with the complainant and Novi Oaks staff, I do not have sufficient evidence to determine that Resident J was left on the floor unattended on 05/21/2021, or that Resident J was left in bed because there were not sufficient staff available to assist him. I concluded that the staff provided supervision and personal care as defined in the act and as specified in Resident D's assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/13/2021, I interviewed licensee designee, Mike Fields via telephone. Mr. Fields stated that he purchased a bed pad with handles for the staff to use to transfer Resident D. Mr. Fields stated that he did not have a receipt for the purchase, but he made the decision to order it as a support for staff when transferring residents. Mr. Fields stated that there was no written authorization from a physician to use a bed pad to transfer Resident D.

On 09/13/2021, I conducted the exit conference with Mr. Fields via telephone. I shared my findings. Later the same day, I received an acceptable corrective action plan via email from Mr. Fields.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	I concluded that Mr. Fields purchased a bed pad with handles for Novi Oaks staff to use to transfer Resident D. There was no written authorization by a licensed physician or documentation in Resident D's IPOS to authorize the use of the bed pad for transfer purposes.
CONCLUSION:	VIOLATION ESTABLISHED

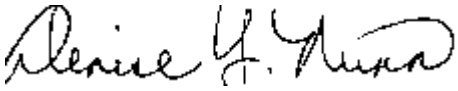
IV. RECOMMENDATION

I recommend that the special investigation be closed with no change to the status of the license.

09/14/2021

Kenyatta Lewis Date
Licensing Consultant

Approved By:



10/21/2021

Denise Y. Nunn Date
Area Manager